BWC
Better Workers' Compensation
Built with *you* in mind.

Settlement Application for Non-complying Employer Claims

Ohio Administrative Code 4123-14-05

- This form is to be used by the employer and/or employer's representative to request a decision by the Adjudicating Committee to settle the employer's non-compliance liability to the state insurance fund.
- This request must be signed by the employer and be notarized.
- Attach current financial information (a copy of the past three years, Federal and State income tax returns) to this application.
- Mail completed, signed and notarized form to: BWC, Legal Operations, Settlement Unit, P.O. Box 15398, Columbus, OH 43215-0398 **OR** fax to (614) 719-5941. Please call (614) 752-9040 with questions.

Employer name		Policy number	
Employer Contact name	Telephone number ( )	Fax number ( )	
Street address		E-mail address	
City		State	ZIP code
Injured worker name	Claim number(s)		
Street address	City	State	ZIP code

1. State reasons why a settlement would be in the best interest of both the applicant and the State of Ohio.

2. Number of employees hired by applicant .....

3. Location of employer business

4. Length of time employer has been in business .....

5. Nature and type of employer business

6. Please explain why the employer did not have workers' compensation coverage when the injured worker was injured.

7. Dollar amount employer proposes to pay for settlement ..... $
   Note: Payment arrangements may be requested.

8. Is the employer presently carrying workers' compensation coverage? ..... ☐ Yes ☐ No If no, please state the reason why.

9. Additional information you feel is relevant to your request

☐ Attachments (please list):

The information contained in said application is true to the best of my knowledge.

Officer's signature

Title Date

Sworn to before me and signed in my presence this day of , .

Notary Public, State of

BWC-3516 (4/19/2002)
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